Workshop IV: Social Conditions

Community Health Champions

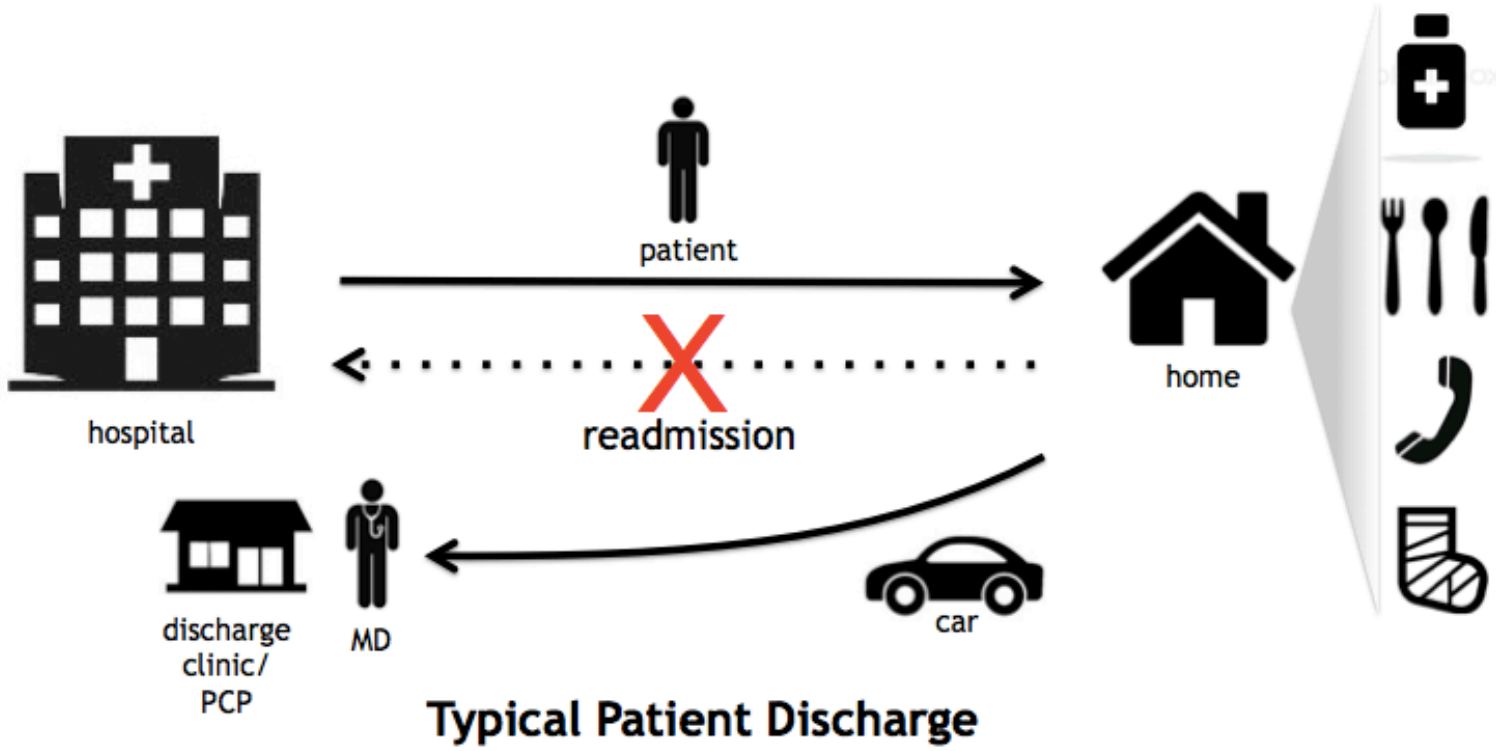
Tuesday, November 12, 2019

CENTRAL HEALTH

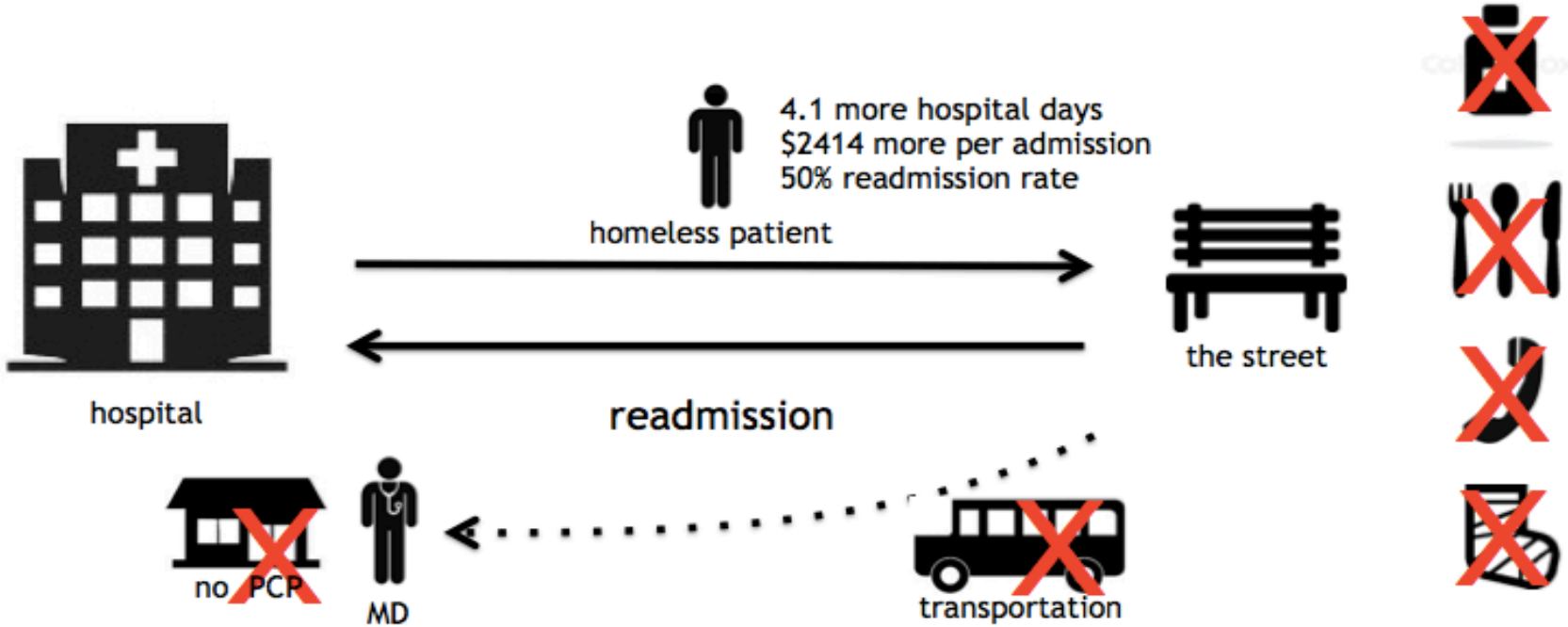
COMMUNITY HEALTH CHAMPIONS by CENTRAL HEALTH

Health Care for the Homeless

Dr. Audrey Kuang, Internal Medicine, CommUnityCare
Josh Rivera, Practice Administrator, CommUnityCare

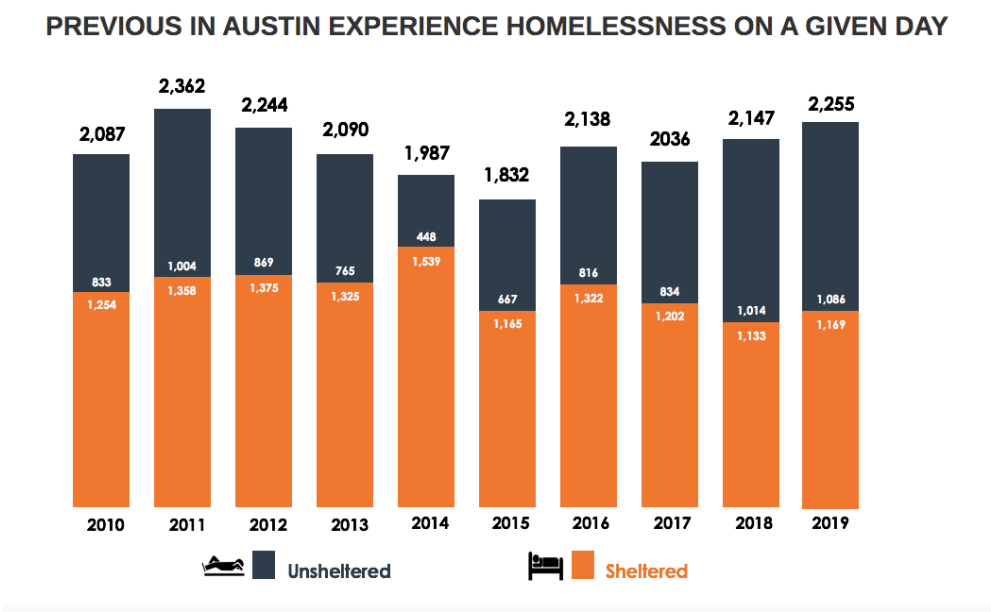


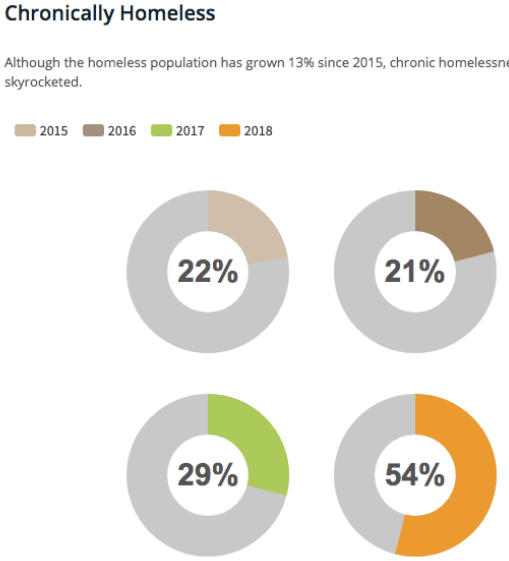
Typical Patient Discharge



Discharge of a Homeless Patient

Homelessness in Austin



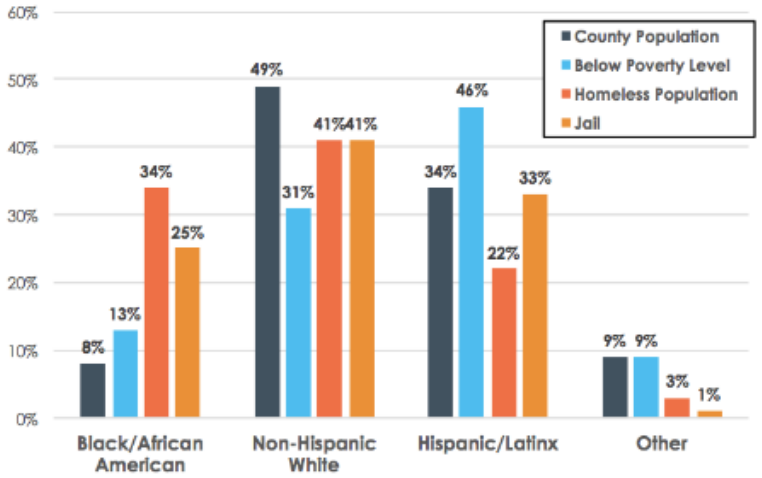


Disparities in Homelessness

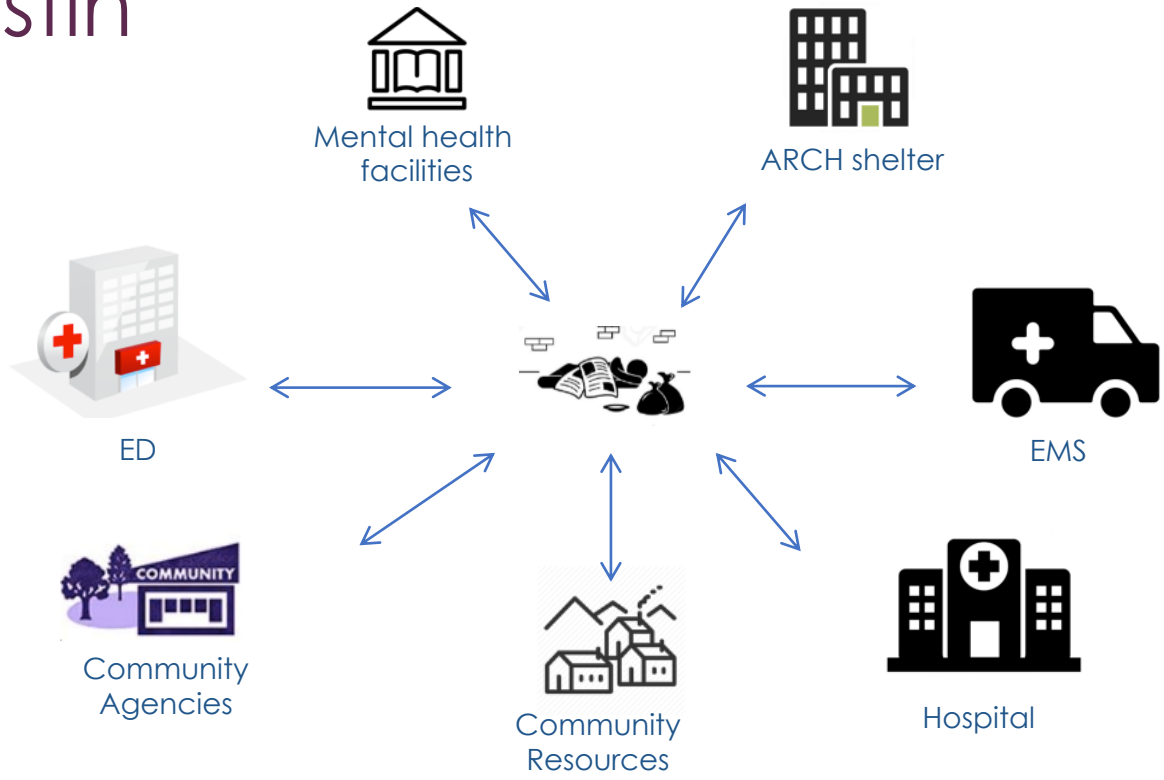
- Mortality
  - General Population: 78.6 years
  - HIV-infection on treatment: ~65 – 78 years
  - Breast Cancer: ~68 years
  - Diabetes: ~58– 68 years
  - Smoking: ~68 years

- Homeless, unsheltered: 53 years
  - 3 times higher mortality rate than homeless, sheltered
  - 10 times higher mortality rate than general population

Race/Ethnicity



Health Care for the Homeless in Austin



Homeless Health Care Program Vision

1. To deliver comprehensive, integrated, high quality health care to those individuals experiencing homelessness while being part of a broader strategy to provide stable housing and essential support services.

2. To improve the quality of life for vulnerable populations through community collaboration, leadership and advocacy.

ARCH Shelter Clinic
(2004)

+

Mobile Team-
fixed community sites
(2013)

+

Street Medicine Team
(2014)

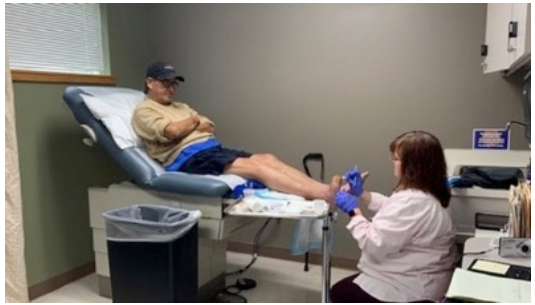
+

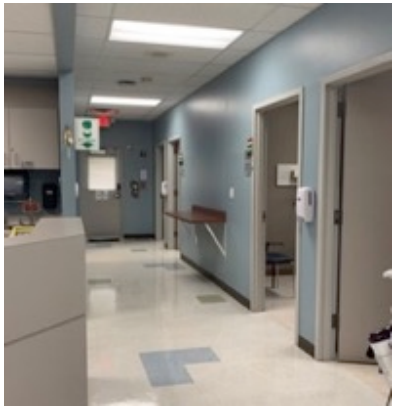
Care Connections Clinic
(2019)

Access to Care

- Shelter Clinic at ARCH (2004)
  - Appointments and walk-ins
  - Case Management
  - Mental health services, lab, TB, testing, Hep C
- Mobile Team (2013)
  - Austin Transitional Center
  - Austin Recovery
  - Sunrise Church
  - Community First Village
  - Foundation Communities
- Street Medicine Program (2014)
  - Acute care
  - Chronic diseases
  - Prescriptions
  - Financial screening

Care Connections Clinic (2019)





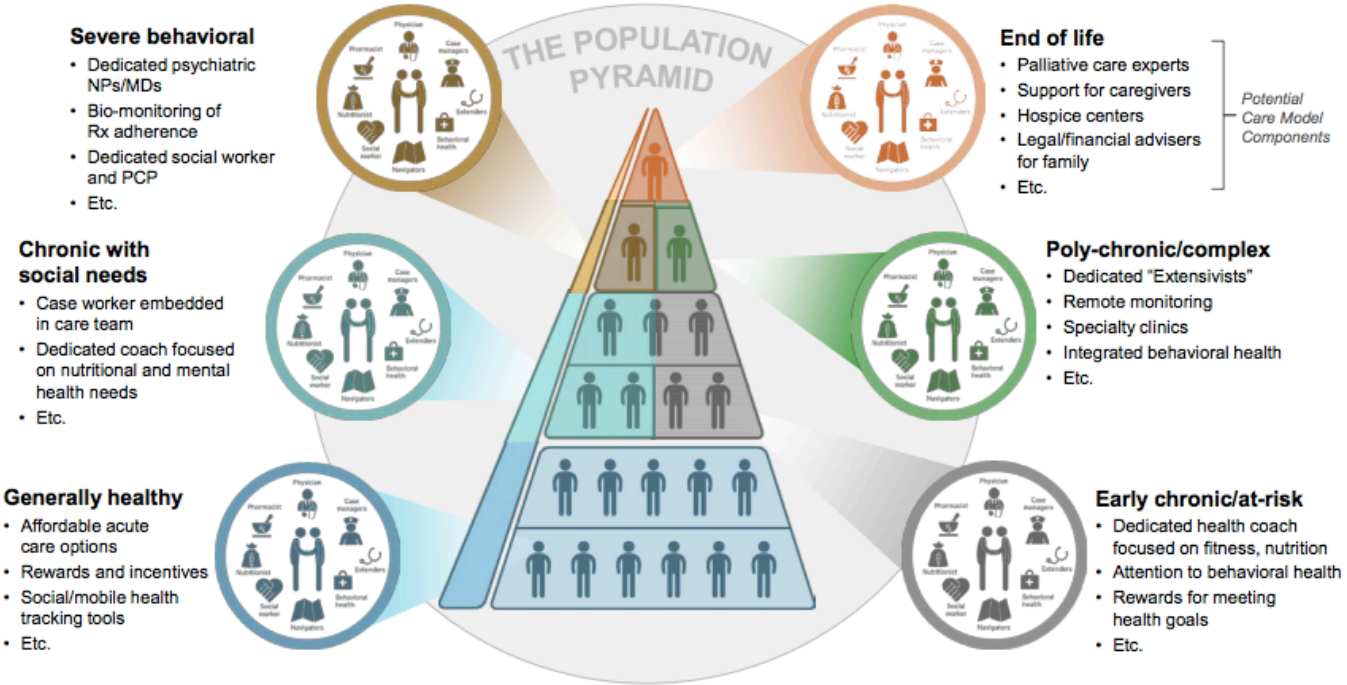
CommUnityCare HEALTH CENTERS + Integral Care + ECHO + Austin-Travis County EMS

Care Connections Clinic (2019)

- Facility:
  - 10 exam rooms
  - Onsite lab
  - Procedure room
- Co-location with:
  - Integral Care
  - ECHO
  - Community Health Paramedics (CHP)
- Care team:
  - Providers
  - Medical Assistant
  - Registered Nurse
- Extended care team:
  - Pharmacist
  - Wound care
  - Social Worker
  - Case Manager

CommUnityCare HEALTH CENTERS + Integral Care + ECHO + Austin-Travis County EMS

The Population Pyramid

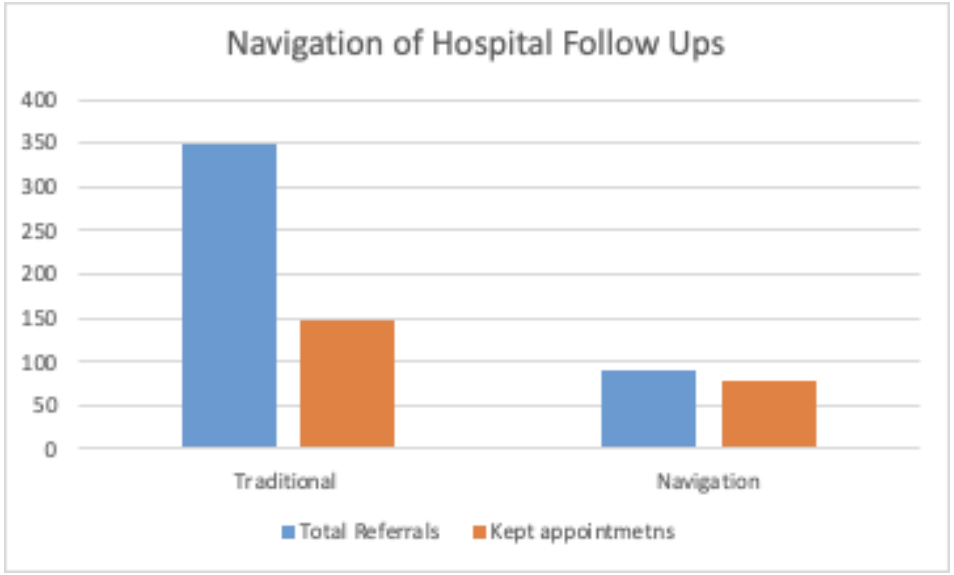


Hep C Treatment

- Over 50 patients at our homeless sites, including Care Connections Clinic
- Treating /Curing Hep C provides **$15,907** in cost savings per year in health care costs associated with the disease
- Breaking down barriers, streamlining care, patient engagement

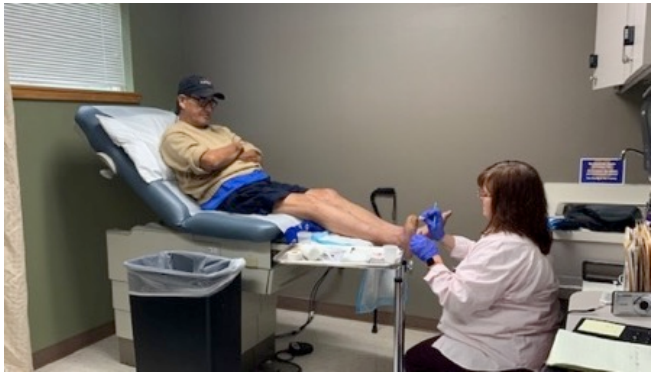
Carlos and his Hep C meds

Transitions of Care



Wound and Foot Care

- 200 wound care visits to 75 unique patients delivered since 2/25/19
- Provided access to patients waiting on access to formal Wound Care Clinic
- Case review suggests avoidance of 15 amputations and/or avoidable hospitalizations

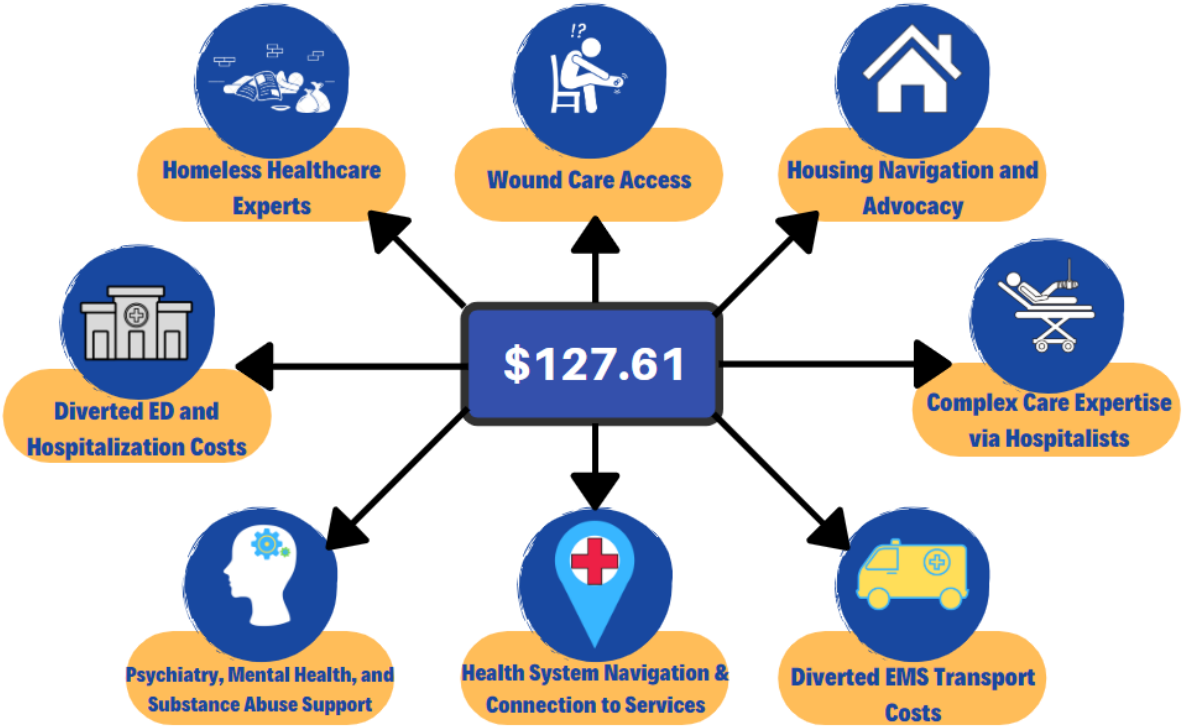


SOAR (SSI/SDI Outreach, Access and Recovery)

- A program to help increase access to SSI/SSDI eligible adults experiencing homelessness, mental illness, medical impairment, and/or substance use disorder.
- SOAR - trained case managers help gather documents and write a cover letter to help support SSI/SSDI claim.
- 10 approvals, 1 denial, 2 approvals after appeals
- SSI $771/mo → Medicaid→ Housing, $1500-$27000 backpay

Mary and her case manger Lauren at Community First Village

$127 Investment in Care Connections



Care Connections Clinic: Community Impact

2/25/2019 – 9/30/2019

Over 2,000 Patients Served

500 Wound Care Services
100 Paracentesis Procedures

Over $50K in Disability Back Pay and Future Benefits for Patients

Over $1.8M in Health System Savings

Estimated Community Impact via Cost Savings, Generated Revenue, and Patient Economic/Social Benefits:

$3.1 MILLION

Approach to Care

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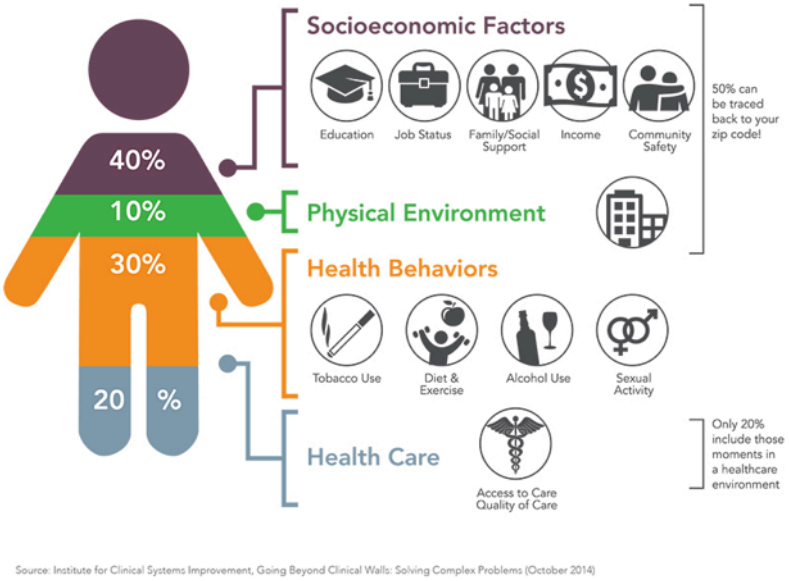
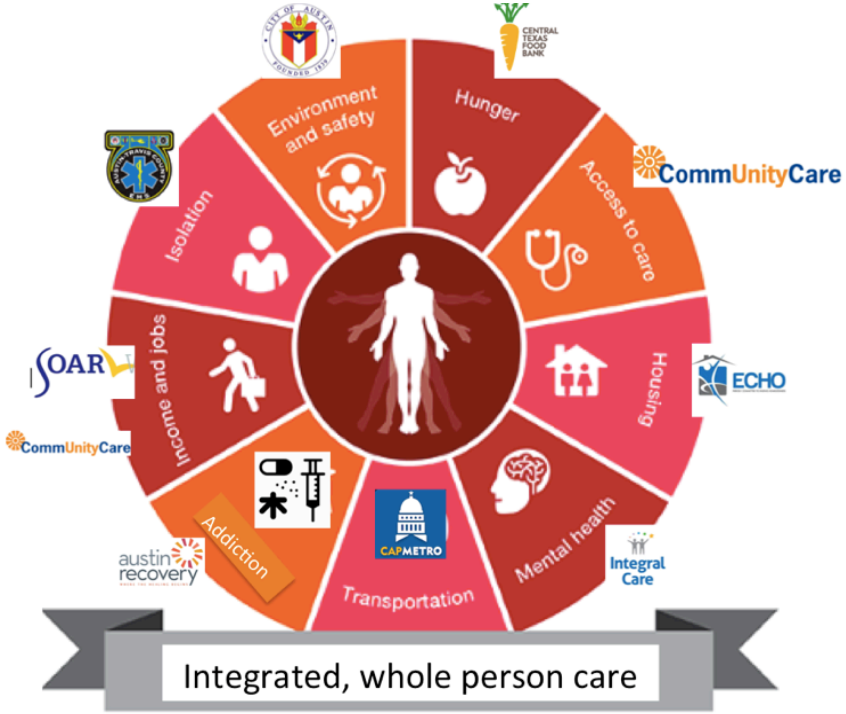
Approach to Care

Organ Systems



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Approach to Care

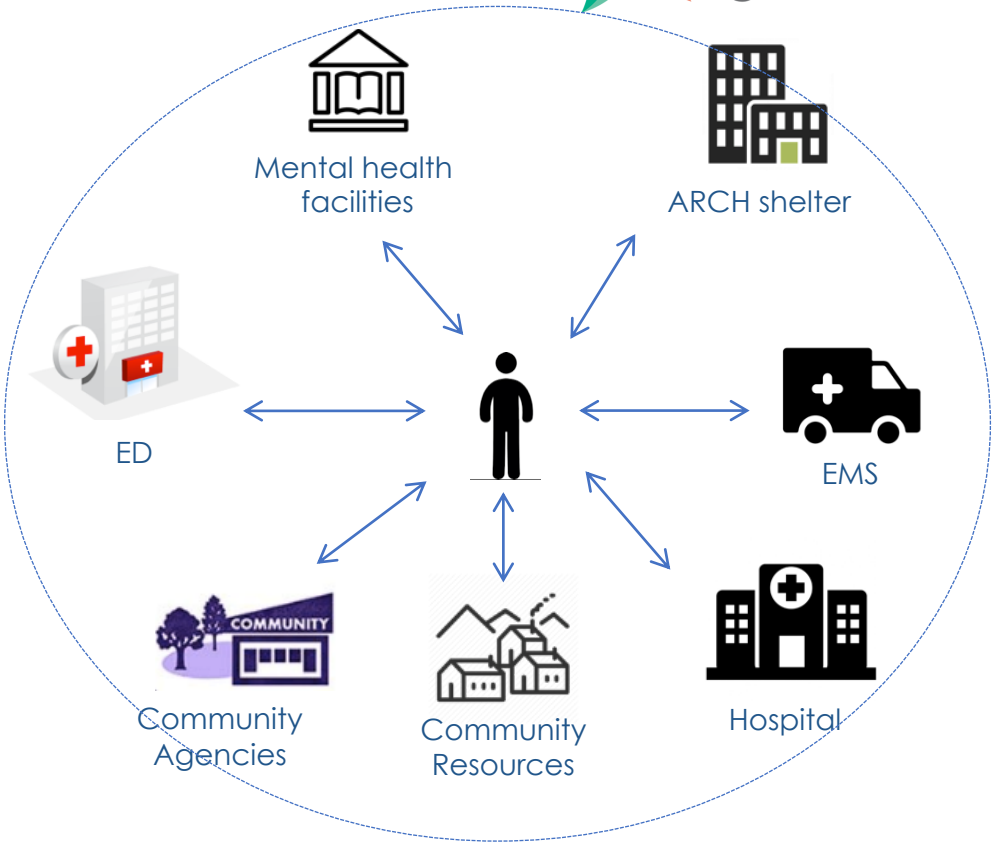


"You can do what I cannot do. I can do what you cannot do. Together we can do great things."

– *Mother Teresa*

Connecting the Care

- Addresses health disparities in a way that is proactive, innovative, and collaborative
- Integrates primary care, mental health care, and social services under one roof
- Proves to be an effective and valuable car delivery model for some of our city's most vulnerable populations

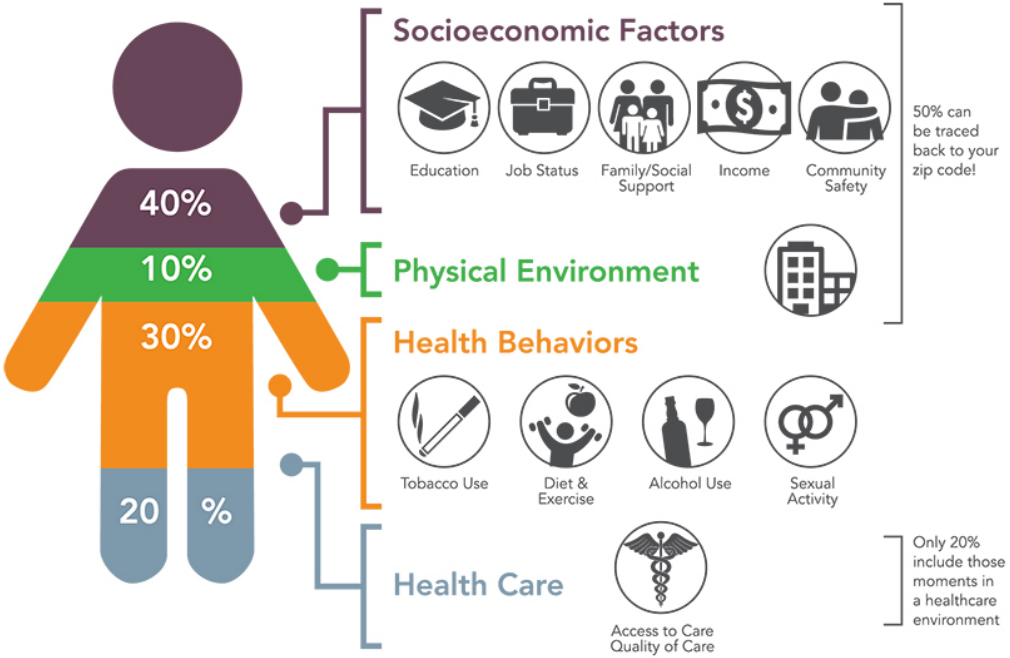


Social Conditions Panel Discussion

Moderated by Vanessa Sweet

Strategy Manager, Central Health

Social Determinants of Health



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Panelists

- Carmen Cardenas, CommUnityCare Health Centers
- Sarah Cook, Central Health
- Eli Covarrubias, Central Health

Announcements

- Surveys
- Social hour – Trudy's South Star
- Final Workshop: December 3
- Annual Celebration: December 12

CENTRAL HEALTH

Health care for **all**

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Community Care Collaborative
A Central Health and Seton partnership

CommUnityCare

SENDERO HEALTH PLANS